FDA COPY

AMERICAN
ASSOCIATION
OF BLOOD BANKS

7162 '99 AUG 24 A9:54

August 20, 1999

Office of Information and Regulatory Affairs
Office of Management and Budget
New Executive Office Building
725 17th Street, NW, Room 10235
Washington, DC 20503
Attn: Wendy Taylor, Desk Officer for FDA

Re: FDA Docket No. 99D-1878: "Draft Guidance for Industry: Current Good Manufacturing Practice for Blood and Blood Components: (1) Quarantine and Disposition of Prior Collections from Donors with Repeatedly Reactive Screening Tests for Hepatitis C Virus (HCV); (2) Supplemental Testing, and the Notification of Consignees and Transfusion Recipients of Donor Test Results for Antibody to HCV (Anti-HCV)" [*Federal Register*: June 22, 1999 (Volume 64, Number 119)] – "HCV Lookback"

To Whom It May Concern:

These comments are filed with the Office of Management and Budget (OMB) on behalf of the Interorganizational HCV Lookback Committee (Committee) created by the American Association of Blood Banks (AABB) to provide assistance to the blood banking community for HCV lookback. The members of the Committee represent the AABB, America's Blood Centers (ABC), and the American Red Cross (ARC), and represent all of the blood collecting organizations and over 80% of the blood transfusion services in the United States. The Committee appreciates the opportunity to comment on the information collection requirements of this draft guidance.

As anticipated, this draft guidance incorporates extension of lookback to include HCV 1.0. This was expected and the requirements are an excellent compromise of science and practicality. However, the Committee does have three major concerns about the guidance requirements as it impacts information collection. These concerns address 1. FDA's underestimation of the burden of this required HCV lookback program, 2. the need to collect accurate information relative to the time, expense and effectiveness of this lookback program for analysis and use in decisions related to possible future required lookback programs, and 3. an unnecessary new requirement.

99D-1878 C 21

8101 Glenbrook Road ♦ Bethesda, MD 20814-2749 ♦ Phone: (301) 907-6977 ♦ Fax: (301) 907-6895
Web site: www.aabb.org ♦ Email: aabb@aabb.org

1. FDA's Underestimation of the Burden of this Required HCV Lookback Program

The Committee believes that the burden is significantly greater than that estimated by FDA. For example, the total annual responses and associated hours per response and total annual recordkeeping and associated hours per recordkeeper are significantly underestimated by the FDA. The Committee believes the actual total will be far greater than that estimated by FDA. While some of the records involved are accessible by computer (electronic), many of the records to be examined are paper records, requiring far greater hours than projected by FDA. This type of recordkeeping examination, electronic or paper, is highly labor intensive and requires sustained attention to detail on the part of the examiner.

The FDA notes that there are no capital costs or operating and maintenance costs associated with the required HCV lookback program (these terms are undefined by FDA). To the contrary, there are costs associated with inputting and maintaining both files and records of an HCV lookback program as well as the costs of storing this information whether it be in electronic or paper form. Also, a number of blood establishments have had to acquire additional equipment and space for reviewing existing records.

Additionally, the FDA did not consider the expense for the additional training that is required to undertake such a lookback program.

These underestimated hours combined with a new and unnecessary requirement (see No. 3 below) make it evident that the costs associated with the FDA's information collection proposal will certainly be far more than what FDA estimates.

2. Need to Collect Accurate Information Relative to the Time, Expense and Effectiveness of this Lookback Program for Analysis and Use In Possible Future Required Lookback Programs

The Committee believes tracking the time, expense and effectiveness of this required HCV lookback program will provide useful information for possible future required lookback programs. The Centers for Disease Control and Prevention (CDC) has been charged with this effort and the Committee strongly recommends that the Department of Health and Human Services strongly support this effort. The Committee recommends that the CDC implement a reporting system with respect to HCV lookback efforts that will collect information necessary to evaluate the time, expense, and most importantly of all, the effectiveness of this lookback effort. The Committee makes this request believing that the reported results will demonstrate the limited value of the lookback effort, as some of the data below demonstrates. Nonetheless, such a reporting system and the resulting information would be extremely valuable should similar lookback initiatives be considered in the future.

3. Unnecessary New Requirement

The draft guidance now contains a totally unexpected new requirement to "identify prior collections extending back indefinitely to the extent that electronic or other readily retrievable records exist." This change is analogous to moving the finish

line while the race is still in progress, and after some of the participants have completed the race and gone home. We urgently request that this new provision be deleted based on the following concerns.

- **First, we believe that this requirement will result in an unintended slowing of the present lookback efforts.**

The current effort is very time consuming for blood collection facilities and hospital transfusion services. The further back in time a search must be conducted, the greater the proportion of recipients deceased or lost to follow-up, and the greater the proportion of record retrieval that will be manual rather than electronic. Extending lookback to HCV 1.0 will require even more time and effort than for HCV 2.0/3.0 because of the intense manual effort required.

Furthermore, locating and reviewing the actual test results (both initial and repeat reactive) and performing the Signal to Cutoff (S/CO) calculation is considerably more time consuming than just looking at the final test interpretation. We are concerned that extending all lookbacks as far as they can go, which will be the effect of this guidance, will bog the system down with minimal reward in terms of infected recipients identified.

- **Second, this requirement will force reopening of many completed lookback cases.**

This commitment of resources must be done without knowledge of whether the hospital can also search its records that far back. The specific consignee hospital is not identified until after the donor test record has been researched, so even if it is known that a particular hospital does not have records, the blood collection agency must do the initial research. It is highly unlikely that a blood collection agency will find that none of its consignees have such records, so effort involved in initial identification of donor records must proceed even when there is little chance that recipient identification and notification will occur.

This is an ineffective use of time and resources that could be more usefully applied to completing the process already underway based on the September 1998 guidance and to completing HCV 1.0 lookback. According to the July 1999 progress survey of 171 blood collection facilities, 38 facilities (22%) have completed 25% or less of the required record review and 56 facilities (33%) have completed 25% or less of consignee notifications. In that same survey, only 99 facilities (58%) have completed the record review and only 69 facilities (40%) have completed consignee notification. It is clear that resources should be directed to completing the HCV 2.0/3.0 lookback as currently defined, without diverting resources to expand to indefinite and less productive record review.

- **Third, we question the value of extending record review back indefinitely**.

Inasmuch as retention of transfusion service records was previously required only for 5 years, and given the mortality of transfusion recipients from underlying disease, there is little value achieved from this extension. The more recent requirement for maintaining records for 10 years and the more recent increased use of computerized record systems do

not assist a retrieval of records from over a decade ago. Data from surveys of AABB member institutions last year, and again this year, indicated that fewer than half had records extending far enough back beyond 1988 to make this extension worthwhile, and many who did have records available expressed concerns about the conditions of the records and the ability to obtain the necessary information.

Data on the mortality rate of blood recipients identified for lookback notification has been compiled from the effort to date on HCV 2.0/3.0 retrospective lookback.

> In Pittsburgh three tertiary hospitals evaluated 1125 recipients and 603 (54%) were deceased; one Children's hospital evaluated 97 recipients, and 55 (57%) were deceased and; three community hospitals evaluated 108 recipients and 78 (72%) were deceased. The overall mortality rate was 738/1330 or 55%.
>
> This is consistent with data from a Midwest hospital in which the Social Security Death Index indicated that 55 of 113 traceable recipients (49%) were deceased. The final number rose to 63 (57%) as a result of subsequent aggressive recipient notification efforts.
>
> Data from the AABB July progress survey shows that records indicated 4183 of 10,088 (42%) of identified recipients were deceased, consistent with the CJD Lookback Study being conducted by the National Blood Data Resource Center in which data through June 1999 shows that of 283 identified recipients, 158 or 56% were deceased.

The Committee also asked that same Midwest hospital to provide data on the effectiveness of lookback. This general hospital with a large cardiac surgery program, identified 141 components that required recipient tracing and located 113 records in which transfusion had occurred. As referenced above, 55 recipients were known to be deceased and 58 notifications were sent out. Out of 58 notifications sent out, 43 recipients were located. Three were spouses/children notifying the hospital that the recipient was deceased and the other 40 were tested. Of the 40 that were tested, 3 tested positive, with one of them already being aware of the positive test results. Thus the lookback objective of identifying transfused recipients who do not know of their infection, was successful in only 2 cases out of 141 potential cases.

Data was also obtained from a blood center with 160,000 collections per year as follows:

397 notifications were sent

200 responses were received. These 200 responses are broken down as follows:

132	deceased recipients
5	recipients lost to follow-up
23	discarded components
29	recipients not notified/unknown
9	recipients newly tested and non-reactive
2	recipients previously tested and previously positive

The Committee believes that this is a typical scenario, and that it is unreasonable to extend the lookback beyond the current time frame. As the records get older, the yield is expected to be even less.

- **The Advisory Committee on Blood Safety and Availability (Advisory Committee) understood the incrementally smaller returns to be expected as the process was extended further back and thus recommended that the initial program of targeted lookback extend only to 1988 pending a review of the effectiveness of the initial effort. The Advisory Committee has not stated a different position, and we believe it would be wise to continue to comply with their recommendation.**

The Committee reminds OMB that targeted lookback was intended to be conducted in tandem with a CDC effort to inform the general public that anyone transfused prior to 1992 (or with behavioral risks for HCV infection) should be tested for HCV. We believe that that mechanism will be more effective in achieving the underlying public health objectives of lookback and can be done in a more timely manner than extension of the targeted lookback beyond 1988.

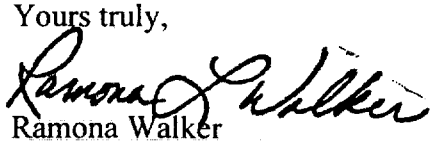
It is understood that the CDC's generalized lookback effort will not reach all potentially infected individuals with a message that prompts them to seek treatment and testing. The experience of the Hoxworth Blood Center in Cincinnati with such a program shortly after the implementation of anti-HCV testing resulted in the testing of only about 5% of the target audience. (Transfusion 1990;30:759-61), and the response rate is no greater when targeted lookback efforts are utilized.

A report of the results of the targeted HCV lookback effort in Milwaukee illustrated that less than 3% of lookbacks resulted in the recipient being tested. (Transfusion 1998;38:4S) Even when the target infection is HIV, with attendant greater public concern, only about 4% of recipients in the San Francisco area receiving a letter urging them to be tested following receipt of a higher-risk unit sought HIV testing. (Transfusion 1991;31:655-61.) Therefore, while the Committee understands the importance of advising potentially infected transfusion recipients of their (increased) risk, it is questionable whether a targeted lookback will provide a greater yield than a generalized one. Consequently, the Committee believes that as the logistic obstacles in lengthening the lookback period increase, there is even greater reason to rely on the generalized lookback.

Once again, the Committee strongly requests the elimination of this new provision. As mentioned above, this new and unexpected requirement combined with the FDA's underestimation of the burden of HCV lookback, creates an unaccounted and unnecessary burden imposed on the blood industry.

The Interorganizational HCV Lookback Committee appreciates the opportunity to comment on the information collection requirements of this draft HCV guidance. The committee is available to assist the OMB in any way. Any question or comments for the committee should be directed to Kay Gregory, AABB Director Regulatory Affairs at 301-215-6522 or *kayg@aabb.org.*

Yours truly,



Ramona Walker
Chair, HCV Lookback Committee

c: Food and Drug Administration